

Case Report

Bariatric Surgery and Multiple Personality Disorder: Complexities and Nuances of Care

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Background: Multiple personality disorder (MPD) can occur in patients with morbid obesity in need of bariatric surgery, though few reports noting this association exist in the literature. Herein we address MPD in morbid obesity, in the context of a patient presenting to us seeking surgical treatment of her morbid obesity.

Methods: A 31-year-old morbidly obese (BMI 49 kg/m²) Hispanic female presented in early 1994 requesting bariatric surgery. She had been a victim of violent sexual abuse as a young girl. Subsequently, she developed at least three personalities, including one male personality.

Results: Although she has lost nearly 45 kg after gastroplasty, her care has been complicated by her named multiple personalities. While MPD are infrequent and unfamiliar to most care providers, successful outcomes can be promoted with a proper approach.

Conclusions: This patient's care illustrates that: (1) all personalities must agree to proposed operative intervention; (2) consent must be obtained from the 'true' patient; and (3) postoperative care and follow-up must address all personalities for an optimal outcome.

Key words: Bariatric surgery, dissociative disorders, morbid obesity, multiple personality disorder.

Introduction

Severely obese patients are faced with a variety of health-related consequences of their body habitus. In addition to the obvious physical manifestations, psychiatric issues often arise in morbidly obese patients, many times out of proportion to that seen in the general population. In 1992, Black *et al.* screened 88 morbidly obese patients for affective disorders and compared them to 76 normal weight subjects matched for age.¹ They documented that 84% of the morbidly obese patients suffered from a major mental disorder compared with 59% in the comparison group. They also showed that morbidly obese patients were more likely to have multiple psychiatric disorders, the most common of which are anxiety and affective disorders. That same year a report by Powers *et al.*² showed that 45% of morbidly obese patients carry an axis I diagnosis, 76% of which have an affective disorder – most commonly major depression. Twenty percent of the patients in this study had an axis II diagnosis with the most common being dependent personality disorder.

Multiple personality disorder (MPD) is part of a group of psychiatric illnesses known as dissociative disorders. MPD (often called dissociative identity disorder) has specific criteria for diagnosis as defined by DSM-IV.³ They are: (1) presence of one or more distinct identities or personality states; (2) at least two identities that recurrently take control of the person's behavior; (3) inability to recall important personal information that is

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too extensive to be explained by ordinary forgetfulness; and (4) the disturbance is not due to the physiological effect of alcohol or a drug. MPD was once thought to be an extremely rare disorder with the number of patients afflicted worldwide estimated to be 200 in 1980.⁴ With published case reports, awareness of this disorder increased and by 1986, nearly 6000 patients were being treated for MPD in North America alone.⁵ Acknowledgment of the previously unrecognized prevalence of this disorder was made when DSM-III-R stated that MPD "might not be as rare as previously thought".⁶

There is a paucity of published data describing MPD in morbidly obese patients. One case has been described in a letter to the editor in 1993 in which McDanal describes a morbidly obese 36-year-old woman who had developed a personality state that used overeating as a coping mechanism. After treatment with hypnosis, the patient experienced a 45 kg weight loss.⁷ In a related letter, Wetsman recommends screening of morbidly obese patients for dissociative disorders and states that bariatric surgery should not be undertaken in a patient who possesses an identity that surreptitiously overeats or sabotages weight-loss efforts.⁸ No formal study has been done to determine the incidence of MPD in the morbidly obese patient population or its effect on weight loss following bariatric surgery.

In this report we discuss the care of a morbidly obese patient with MPD who presented to us in 1994 seeking bariatric surgery. Over the course of her treatment, several salient points regarding her care, and care of such patients in general, became apparent. The purpose of this report is to present these findings in the context of her struggle with morbid obesity, her surgery, and each of her distinct personality states.

Case Report

Psychiatric Issues

The patient is a 31-year-old Hispanic female who was diagnosed with MPD in 1992, 2 years prior to her presentation to us. She has a long history of major depression with several suicide attempts dating back to adolescence. Her most recent attempt at suicide was 5 years prior to her presentation. In the interim, she developed three distinct personality states. The first is a 22-year-old Hispanic female also suffering from depression. She does not speak Eng-

lish and is very self-conscious about her weight. The second personality state is a 40-year-old white female who frequently engages in promiscuous relationships. She is aware of her obesity and would like to lose weight but does not consider weight loss a priority. The last personality state is a 57-year-old white male with a history of alcohol and drug abuse. He is happy with his present weight and has no interest in pursuing weight-loss measures.

Obesity Issues

The patient is 160 cm tall and weighs 126 kg. She weighs 241% of her ideal body weight and has a body mass index of 49 kg/m². She has been obese for most of her life and weighed 84 kg at the age of 15 years. Her morbid obesity has manifested physically with hypertension and sleep apnea, which requires supplemental oxygen at night. She denies being a sweets eater and has failed to lose weight through various weight loss programs including physician-supervised diets. She is single, lives with her parents, and is disabled due to complications related to alcohol and drug abuse in the remote past.

Prior to surgery, extensive psychiatric evaluation was undertaken to determine if the patient was a suitable candidate for surgery. The decision to operate came after several months of coordinated efforts and meetings between the patient, surgeon, and psychiatrist. At these meetings each personality state was addressed and their expectations outlined. The goal prior to surgery was for all identities to agree to surgical treatment and be dedicated to losing weight.

One month after undergoing vertical banded gastropasty the patient had lost 9 kg and continued to lose weight over the following several months. During this period of time, she and her personality states were in harmony and focused on the goal of weight loss. Six months after her surgery, however, her weight loss slowed tremendously. Compliance became an issue as her identities began to enter a state of turmoil. The male personality was becoming tired of having to eat small meals and felt that he was too old to learn new eating habits. He began to revert to his old eating habits of overeating resulting in frequent vomiting. This continued to worsen necessitating several admissions for dehydration. The younger, female personality state began to regret having surgery while the older female personality was becoming increasingly depressed. The patient reached a maximum weight loss of 36 kg 2 years after surgery and has now begun to regain some of

this lost weight as those personality states less interested in losing weight become more dominant. When it became apparent that the patient was gaining weight despite a concerted effort on her part to lose it, each individual personality state was summoned. Upon interviewing each identity, we determined that the patient's efforts were being thwarted by the male personality. At this point a written contract was drawn up with the patient outlining a plan. In the contract, the patient agreed to make greater efforts to lose weight, to eat three small meals per day, and to address the male personality's insurrection with her psychiatrist. Since then the patient has done better. Her missed clinic appointments occur less frequently, and her weight has plateaued. At 3.5 years after her operation she weighs 93 kg (33 kg less than her preoperative weight) and is at 178% of her ideal body weight.

Discussion

Several important issues were brought to light in caring for this patient. First and foremost, all personality states must be identified. This may not be easy, particularly since many of the personality states may not wish to be identified. These personality states have developed for a reason, often as a result of physical and/or sexual abuse during childhood,⁹ and they may not want to be identified, for fear of repercussions. An empathic, understanding relationship between surgeon and patient is helpful in working through this aspect of the preoperative evaluation.

The possibility that one or more of the personality states may not wish to undergo bariatric surgery and lose weight must also be considered. The personalities have played a role in protecting the patient's emotional well-being from the pressures that drove the patient to develop morbid obesity and may believe that weight loss will again place the patient in physical or emotional danger (i.e. sexual abuse). Such issues underscore the importance of discussing the planned course of therapy not only with the patient, but also with the other personality states. Such discussion must always be undertaken in a nonthreatening manner. If any personality should not want the patient to lose weight, that personality's agenda must be addressed. Often, the patient will tell you which personality is not in agreement. On other occasions the patient may conceal the identity of the present personality for fear that, once the speaker is identified, efforts will be

undertaken to nullify that personality state's power or input. Obtaining an operative consent is another issue that must be addressed in patients with MPD. Consent must always be obtained from the true patient and not from one of the other personality states. As many of the secondary personalities as possible must also give verbal consent for operative intervention, the dominant ones being most important. Though all personalities might not consent, bariatric surgery may still be undertaken if the dominant personalities support it. If all personalities do not support undertaking bariatric surgery, the discontented personalities warrant especially close follow-up after the bariatric procedure.

Finally, concerted efforts must be undertaken to insure maximal cooperation from each personality. Perioperatively and postoperatively, care givers and the patient's support system should watch for the emergence of new personalities or personalities of a previously lesser profile. This is especially true if the postoperative course is complicated. Complications bring about stress, which can evoke defense mechanisms that may involve personalities other than the patient's own. The high risk period for the emergence of new or lesser personalities may be months after surgery when weight loss has begun to slow. This can be a very frustrating time for the patient and personalities not strongly supporting the procedure initially may become vocal, decrying the procedure. These personalities may account for a diminution in weight loss. These previously lesser personalities can become dominant and disrupt months of co-ordinated care. Their early recognition is the first step in avoiding potential problems brought about by them.

The relationship between the various personality states cannot be overemphasized. One or more of the personalities may become dominant, changing the patient's perspective towards the operation and weight loss. Acknowledgment that all personalities may not want to lose weight may cause friction among the various personalities and turmoil within the patient. Such disturbance and inner controversy is most certainly very unsettling and may promote the invocation of defense mechanisms involving the consumption of food and drink. These very defense mechanisms, in all probability, led to the development of morbid obesity in the first place. Stated differently, weight loss and the anxiety that goes with weight loss induce changes in the balance of the multiple personality states. The changing balance brings

about further anxiety and uncertainty, undermining the focus on weight loss and decreasing the probability of success. If unchecked, the combination of anxiety, frustration, turmoil, and internal fighting might lead to extreme eating disorders.

Inner turmoil may be exacerbated should the patient request to review his or her medical record – an undeniable right. Review of the medical record by a patient with MPD, however, is potentially catastrophic because it may give the patient an unfiltered view of how he/she is seen by others. Although multiple personality states exist, the patients do not see themselves as mentally ill, because all the personality states are logical or appropriate in their own right. Thus, patients with MPD might be vulnerable to more upset if given unabridged access to their medical record. If requested by the patient, the medical record should be reviewed with the physician guiding the patient and explaining compassionately as the chart is reviewed.

Important issues in dealing with the morbidly obese patient with MPD can be summarized in three words: consent, consensus, and cooperation. Obtain consent from as many personalities as possible in pursuit of a consensus. Address each personality in a nonthreatening manner to maximize cooperation with the care plan. Request that 'everyone' be present for discussions regarding surgery and insure that 'everybody' is in agreement. Solicit questions and establish that 'everyone' is comfortable with the decision to undergo bariatric surgery. These simple guidelines may not eliminate potential problems when dealing with patients with MPD disorder, but, with guidance

and support from Psychiatric colleagues, they may circumvent some of the pitfalls frequently encountered.

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